3.1 AMOUNT, DURATION, AND SCOPE OF ASSISTANCE

ATTACHMENT 3.1-A AND 3.1-B

Amount, duration and scope of medical and remedial care and services provided.

1. Inpatient Hospital Services

Effective 4-1-90 coverage for medically necessary inpatient hospital services for recipients age 21 and older in a Medicare approved general hospital is limited to 25 days in a fiscal year, July 1 through June 30.

Preadmission review of medical necessity and prior authorization required except for normal deliveries and newborn care.

2. a. Outpatient Hospital Services

Outpatient hospital services include laboratory and radiological services, emergency room services, ambulatory surgical services, and other items and services generally furnished by hospitals in the State. These services may be limited in frequency/duration, or may require prior approval by the State.

2. c. Federally Qualified Health Center Services

Other ambulatory services furnished by a FQHC may be limited in frequency/duration or by prior authorization as is applied to that service when furnished by other Medicaid providers.

4. a. Nursing Facility Services

Pre-certification to determine the medical necessity for inpatient services prior to authorization of benefits.

4. b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

Vision Services - diagnosis and treatment for defects in vision including eyeglasses.

Dental Services - palliative treatment to relieve pain, eliminate infections, or reduce fractures; restorations to preserve dentition of the teeth; x-ray studies; preventative services; endodontics; periodontics; prosthodontics; oral surgery; orthodontics.

Hearing Services - diagnosis and treatment for defects in hearing including hearing aids.

Other Services - services described in Section 1905(a) necessary to correct or ameliorate defects and conditions identified by the screening services.

(i) Rehabilitation Hospital Services

(ii) Organ Transplant Services

5. a. Physicians' Services

Services may be limited by specialty, e.g., pathology, radiology, or by frequency/duration or by prior authorization.

Vision care services for individuals age 21 and over will be limited to examination to determine the need for eyeglasses at three year intervals, if medically indicated; and dispensing of eyeglasses also at three year intervals, if medically justified. Adults who have received examination since January 1, 1992, will not be eligible for re-examination until 36 months have elapsed from the date of the last examination.

5. b. Medical and Surgical Services Provided by a Dentist

Limitations placed on the procedure for physicians apply when that service is provided by a dentist. Dental coverage for individuals age 21 and over will be limited to repair of fractures of the maxilla and mandible, and certain surgical procedures which can be performed by a physician or oral surgeon.

6. a. Podiatrists' Services

Services may be limited in amount/duration, or by prior authorization. Limitations placed on the service (procedure) for other qualified practitioners apply when the service is provided by a podiatrist.

6. b. Optometrists' Services

Services may be limited in amount/duration, or by prior authorization. Limitations placed on the service (procedure) for other qualified practitioners apply when the service is provided by an optometrist. Vision care services for individuals age 21 and over will be limited to examination to determine the need for eyeglasses at three year

intervals, if medically indicated; and dispensing of eyeglasses, also at three year intervals, if medically justified. Adults who have received examination since January 1, 1992 will not be eligible for reexamination until 36 months have lapsed from the date of the last examination.

6. c. **Chiropractors' services**

Services consist of manual manipulation of the spine to correct a subluxation and radiological examinations related to the service. Coverage is limited to twelve (12) treatments in a twelve month period. Additional treatments require prior authorization.

d. **Other-practitioners' services**

Psychologists: Prior authorization is required for psychotherapy after initial 10 sessions.

7. **Home health services**

a., b., c. Prior authorization is required.

8. **Private Duty Nursing**

Prior authorization is required.

9. **Clinic Services**

Services may be limited by prior authorization.

School Health Services-Personal Care

Services related to a child's physical and behavioral requirements, including assistance with eating, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, use of adaptive equipment, ambulation and exercise, behavior modification, and other remedial services necessary to promote a child's ability to participate in, and benefit from, the educational setting. Services are furnished by providers who have satisfactorily completed a program for home health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions. Providers must meet the qualifications established by the Medicaid agency and the Department of Education or the Local Education Agency (LEA). Personal Care providers must be employed or under contract with a school or school district. Personal care services are not covered when provided to recipients by their parents, including natural, adoptive and step-parents.

Services must be ordered pursuant to an Individualized Education Plan (IEP) as defined under Part B of the Individuals with Disabilities Education Act (IDEA).

School Health Services - Health Needs Assessment and Treatment Planning

Services designed to evaluate and assess a child's health needs, identify the most appropriate amount, duration and scope of health services to meet a child's health needs, and develop a plan of care to permit coordination and monitoring of services. Services are furnished by qualified providers who, based on their education, training and experience, are designated as such by the Medicaid agency and the Department of Education or the Local Education Agency (LEA).

10. **Dental Services**

Prior Authorization may be required for restorative/replacement procedures.

11. a. Physical Therapy

Prior authorization required for more than ten visits.

b. Occupational Therapy

Prior authorization required for more than ten visits.

c. Services for Individuals with Speech, Hearing and Language Disorders

Prior authorization is required for therapy. Hearing aid evaluations, hearing aids, hearing aid supplies, batteries, and repairs are limited to recipients under 21 years of age. Prior authorization is required for hearing aids.

Augmentative/Alternative Communication Devices - DEFINITION

An "Augmentative/Alternative Communication Device" is defined as any electronic or non-electronic aid or device that provides external assistance for communication and is an integral part of a speech-language pathology treatment plan for a person with a communication disorder who cannot functionally communicate basic medical needs, verbally or through gestures, due to a medical condition in which speech is not expected to be restored.

Coverage Criteria

Augmentative/alternative communication devices are covered for use in the communication of basic medical needs only. Devices intended to meet social, educational and vocational needs are not covered.

Augmentative/alternative communication devices must be prescribed by a physician and provided under the direction of a qualified speech/language pathologist trained in augmentative communication devices and services. Prior authorization is required.

At least one of the following criteria must be met before an augmentative communication device can be considered for approval:

- Beneficiary cannot functionally communicate basic medical needs, verbally or through gestures, due to medical conditions in which speech is not expected to be restored.
- Beneficiary cannot, verbally or through gestures, participate in medical care; i.e., making decisions regarding medical care or indicating medical needs.
- Beneficiary cannot, verbally or through gestures, functionally communicate informed consent on medical decisions.

All of the following must be met before an augmentative/alternative communication device can be considered for approval. The communication device must be:

- A reasonable and necessary part of the beneficiary's treatment plan.
- Consistent with the symptoms, diagnosis or medical condition being treated.
- Not furnished for the convenience of the beneficiary, the family, the attending practitioner or other practitioner or supplier.
- Necessary and consistent with generally accepted professional medical standards of care; i.e., not experimental or investigational.
- Established as safe and effective for the beneficiary's treatment protocol.
- Furnished at the most appropriate level which is suitable for use in the beneficiary's home environment.

Requests for augmentative/alternative communication devices must be accompanied by a systematic and comprehensive augmentative evaluation completed by a qualified speech/language pathologist trained in augmentative communication devices and services. Where appropriate, other evaluation team members may include an occupational therapist, physical therapist, psychologist, or rehabilitation engineer. The qualified speech/language pathologist will be directly responsible for management of the communication plan; and for training of any other service provider (which may include a support person such as a parent, guardian, teacher, or occupational therapist) to promote functional use of the augmentative/assistive communication device. The qualified speech/language pathologist shall also be responsible for determining specifications for the device based on outcome of the comprehensive assessment. Training services may be limited in amount, duration and scope.

Coverage of Augmentative/Alternative Communication Devices and Related Equipment

Covered augmentative/alternative communication device equipment includes the items listed below:

(a) Operational Software

(b) Speech synthesizer

(c) Printer (if built in)

(d) Battery Packs

(e) Carrying Case

(f) Adapted access software and speech synthesizer, and any other accessories necessary to adapt a computer for use as an augmentative/assistive communication device if the device is a computer-based system.

(g) Vocabulary application package

(h) Access Device:

1. Switch

2. Switch mount

3. Scanning indicator, optical indicator, head pointer, etc.

(I) Mounting Device to suspend system for use either on wheelchair or desktop.

(j) Adapted access software and/or speech synthesizer, and any other accessories necessary to adapt a recipient owned computer for use as a communication device.

(k) Overlay/multiple location configuration (plastic overlays used for training purposes)

Limitation on Coverage of Augmentative/Alternative Communication Devices

The following items are not medical in nature and are not covered by the Medicaid program:

(1) Printers (unless a built-in component of an Augmentative/Alternative Communication Device as defined in this rule), printer paper, printer cables.

(2) Environmental control devices

(3) Personal computers and related hardware.

Trial Use Period

Up to a six-month trial rental period should be considered for all devices to assure that the chosen device is able to meet the recipient's medical needs. At the end of the trial rental period, if purchase of the device is recommended, documentation of the beneficiary's ability to use the device must be provided. Trial use rental is limited to one device per six-month period. Should the initial device be unsatisfactory to meet the basic medical needs of the beneficiary, other devices will be considered for trial use based on the written recommendation of the prescribing physician and speech language pathologist.

Repair and Replacement

Medicaid reimbursement for repairs and modifications (including upgrades) is available for no more than one augmentative/assistive communication device per recipient.

12. a. Prescribed Drugs

All covered outpatient drugs, whether legend or non-legend, must be prescribed by a physician, or other practitioner qualified under State law. Applicable State and Federal law governing dispensing of drugs and biologicals must be followed.

The prescribed use of the covered outpatient drug must be for a medically accepted indication as defined in 1927(k)(6).

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Covered outpatient drug does not include any drug, biological product or insulin provided as part of or incident to and in the same setting as defined in 1927(k)(3) for which payment includes drugs, biological products and insulin.

Limitations in Coverage

A. Restrictions on medical use of certain drugs or classes of drugs and drug exclusions:

1. Drugs not covered:

a. Agents when used for anorexia or weight gain.

b. Legend agents used for cosmetic purposes or hair growth.

c. Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of title 21 of the Code of Federal Regulations ('DESI' drugs)).

d. Drugs used to promote fertility effective 9-15-93.

e. Agents when used to promote smoking cessation effective 9-15-93. (Includes, but not limited to, nicotine patches and nicotine gum.)

2. Drugs covered with Limitations:

a. Legend drugs (agents) when used for the symptomatic relief of cough and colds when listed as multiple source drugs in the current Federal Upper Limit (FUL) published by the Department of Health and Human Services, Health Care Financing Administration.

b. Legend vitamins A, D, & K except for End Stage Renal Disease (ESRD) program which covers all legend vitamins.

c. Anti-ulcer medications are covered for a 90-day acute dosing period after which they must be decreased to a

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maintenance dose. If the acute dose is to be extended over 90 days, a prior authorization must be issued according to guidelines developed by the Drug Use Review Board.

d. Growth hormones must be prior authorized.

e. Amphetamine use over the age of 17 must be prior authorized.

B. Non-legend drugs are covered as follows with a prescription. Unless otherwise specified, only generic products will be covered.

1. Family planning supplies.
2. Diabetic supplies, syringes, and testing agents.
3. Plain Niacin tablets.
4. Multiple vitamins for children to age 21.
5. Prenatal vitamins for women through age 45.
6. Plain ferrous sulfate, gluconate, furmarate.
7. End Stage Renal Disease (ESRD) vitamins, vitamin/mineral preparations and other medications related to ESRD by approved manufacturers.
8. Other Over the Counter (OTC) Drugs which appear on the West Virginia Medicaid approved coverage list.

C. Quantities and Duration

All covered outpatient drugs are reimbursed up to a 30-day supply per prescription and up to 5 refills per prescription.

The maximum number of prescriptions per eligible per month available without prior approval is ten (10). Prescriptions exceeding ten per eligible per month will require prior authorization from the Rational Drug Therapy Center at the West Virginia University School of Pharmacy.

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Exceptions to Quantities and Duration:

(1) Oral and parenteral antibiotics; opiate agonists, excluding Schedule II drugs; and miscellaneous analgesics and antipyretics are limited to a maximum of 30 days per prescription and one refill per prescription.

(2) Sedatives and hypnotics, excluding phenobarbital, are limited to a 30-day supply per prescription with one refill per prescription.

12. b. Dentures

Prior authorization may be required.

12. c. Prosthetic Devices

Prior authorization may be required for certain procedures.

12. d. Eyeglasses

Certain procedures require narrative description of the service provided or laboratory invoice, or prior authorization.